

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1572

04049

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

James Harold Angle

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1 6 hrs.

min.

9. Birthplace

Palmer, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Joseph Henry James Angle

13. Birthplace Brooklyn, N.Y.

MOTHER

14. Maiden name Mary Elizabeth Barnes

15. Birthplace Adelphi, Md.

16. Informant

Joseph Angle

Address Palmer, Md.

17. Burial

Date thereof 4 30 46

(month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

Brooklyn, Md.

18. Funeral director

J. L. Matthews Bros.

Address

Tradition, Md.

19. M - 30 - 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4 - 30 - 1946, at 11:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-29-1946, to 4-30-1946, at 11:00 a.m.

and that I last saw him alive on 4-30-1946, at 11:00 a.m.

Immediate cause of death Prematurity

birth

Due to malformation

of heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

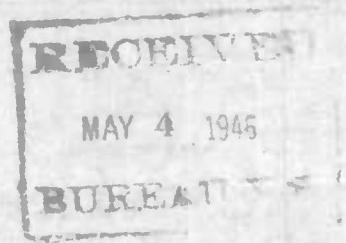
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Avenue and Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-20

04050

## CERTIFICATE OF DEATH

Reg. Dist. No. 286

## 1. PLACE OF DEATH:

County.....

City or town.....

St. Mary's

Rural Palmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

William Edward Augh

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

4 - 29 - 44

6.(c) If alive, give age.....

years

8. AGE:

Years

Months

Days

If less than one day

7 hrs.

min.

9. Birthplace.....

Palmar

(Town, county, and state)

10. Usual occupation.....

None

## 11. Industry or business

FATHER

12. Name

Joseph

Augh

Baltimore

Md

USA

13. Birthplace

Baltimore

Md

USA

14. Maiden name

Josephine

Augh

Baltimore

Md

USA

15. Birthplace

Baltimore

Md

USA

16. Informant

Joseph

Augh

Baltimore

Md

USA

17. Burial

Date thereof

Date thereof

4

30

46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Sacred Heart

Location.....

Baltimore

Md

USA

18. Funeral director

W.C. Mattingly Son

Address.....

Leroy

Augh

Baltimore

Md

USA

19. 4 - 30 - 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

St. Mary's

City or town.....

Rural

Palmar

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4 - 29 - 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 - 29 - 1946, 10:45 A.M. to 4 - 29 - 1946, 10:45 A.M.

and that I last saw him alive on 4 - 29 - 1946, 10:45 A.M.

Immediate cause of death.....

Death

Due to.....

Malformation of heart

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

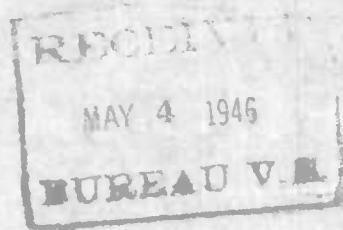
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed 4 - 30 - 1946

T



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH  
of deceased is shown on

2411 N. Charles St., Baltimore 52-2

04051

FILE NO. 101 MAY 3 1946

Reg. Dist. No. 282

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

City or town

St. Mary's

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Mary's Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Robert Bennett Jr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male colored married

6. (b) Name of husband or wife

Mary C. Bennett

7. Birth date of deceased (mo., day, yr.)

Dec. 25 1875

8. (c) If alive, give age years

8. AGE:

Years  
70Months  
71

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Oysterman

11. Industry or business

Aubrey Bennett

12. Name

Maryland

13. Birthplace

Casarly Freeman

14. Maiden name

Unknown

15. Birthplace

Robert Bennett Jr.

16. Informant

Address Ridge, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4/24/46

(month) (day) (year)

Cemetery or crematory

St. Peter's

Location

Ridge Maryland

18. Funeral director

J. L. Robinson

Address

Damascus, Md.

Registrar

19. 4/23 46 Carrasco

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County St. Mary's

City or town Ridge, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Apr. 22 1946, at

1946, 10 AM

and that I last saw him alive on April 22 1946

## Immediate cause of death

trauma

DURATION

2 day

## Due to

Due to malignant tumor - hypernephroma, cur.

Other conditions Retinoblastoma

6 mo.

in left lumbar region.

(Include pregnancy within 8 months of death)

## Major findings of operations

Retinoblastoma inoperable.

Date of op. 4/20/46

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

Julian S. Lane M. D.

Address Leonardtown Date signed 4/24/46

RECEIVED TO THETHAYSO STATE GOVERNMENT

STAGE TO STANDARD

RECEIVED

APR 30 1946

BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

## CERTIFICATE OF DEATH

04052

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County

St. Georges (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Raymond Mace Birch

4. Sex

6. Color or race

6.(a) Single, married, widowed, or divorced

m w married

B.(b) Name of husband or wife

Mary E.

7. Birth date of deceased (mo., day, yr.)

Feb. 18 1871

6.(c) If alive, give age 68 years

8. AGE:

Years Months Days It less than one day  
75 2 1 hrs. min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

retired post master

11. Industry or business

M. Mace Birch

MOTHER FATHER

12. Name

M. Mace Birch

13. Birthplace

Maryland

14. Maiden name

Cannie Taylor

15. Birthplace

Maryland

16. Informant

Mace Birch

Address

St. Georges, Md.

17. Burial

Date thereof 4/22/46  
(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Michael

Location

Bridge, Md.

18. Funeral director

J. B. Robinson

Address

Leonardtown, Md.

19. Date rec'd by registrar

4-19-1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

City or town

St. Georges (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1946 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 14 1946 to April 19 1946

and that I last saw him alive on April 19 1946

Immediate cause of death

Coronary thrombosis

DURATION

3 months

Due to

Due to

Other conditions

Intercurrent nephritis

8 years

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

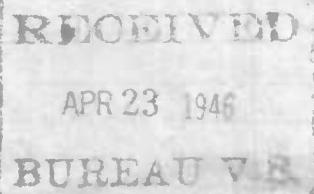
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Great Mills Md. Date signed April 19 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 948

04653

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH: *St Mary*  
 County: *Comptown Md.*  
 City or town: *Comptown Md.* (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *39 years*  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: *Maryland* County: *St. Mary's*  
 City or town: *Comptown* (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: *172* (If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (b) Social Security Number

## 3. (a) FULL NAME

*George E. Bussler*4. Sex: *Male* 5. Color or race: *White* 6.(a) Single, married, widowed, or divorced: *married*6.(b) Name of husband or wife: *Violet Shell Bussler*7. Birth date of deceased (mo., day, yr.): *April 17 - 1890* 6.(c) If alive, give age: *52* years8. AGE: Years: *55* Months: *11* Days: *19* If less than one day: .hrs. .min.9. Birthplace: *Hillville St Mary's Md.* (Town, county, and state)10. Usual occupation: *Merchant*

## 11. Industry or business

12. Name: *John Bussler*13. Birthplace: *German*14. Maiden name: *Kate Knott*15. Birthplace: *St Mary's Co.*16. Informant: *Peter Bussler*Address: *Comptown Md.*17. Burial: *Buried* Date thereof: *April 8 1946* (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory: *Christ cemetery*Location: *Chaptico 2nd st*18. Funeral director: *W.C. Martin* *Funeral Home*Address: *Leonardtown Md.*19. Date rec'd by registrar: *4/3 1946* Cacadeen Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *April 5 - 1946* at *110 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Apr 5 1946* to *Apr 5 1946*and that I last saw him alive on *Apr 5 1946*

Immediate cause of death:

*Anemia*

DURATION

Due to: *Arterio-sclerotic*Due to: Other condition: *Endophlebitis*

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

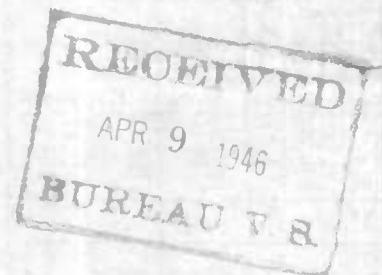
Means of injury

Injured at work?

23. SIGNATURE: *Paul A. Canfield*

M. D. or other

Address: *101 Washington* Date signed: *4/17/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 39

## CERTIFICATE OF DEATH

04154  
Reg. Dist. No. 286

## 1. PLACE OF DEATH

County

St. Mary's  
Rural Bushwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Agnes Gertrude Carter

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

fm col single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 4 - 7 - 46

6.(c) If alive, give age

years

8. AGE: Years Months Days If less than one day  
3 hrs. min.9. Birthplace Rural Bushwood and  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Joseph Ignatius Carter

13. Birthplace Bladensburg and  
Baltimore and

14. Maiden name Mary Katherine Thomas

15. Birthplace Ellicott City and

16. Informant Joseph Ignatius Carter

Address Bushwood and

17. Burial Date thereof 4 - 8 - 46

(Burial, cremation, or removal. Which?) Sealed Heart

Cemetery or crematory

Location Bushwood and

18. Funeral director Juan Ignatius Carter

Address O'Leary and

19. (Date rec'd by registrar) 1946 R.V. Palmer

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County St. Mary's

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4 - 7 - 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 - 7 - 1946 to 4 - 7 - 1946

and that I last saw her alive on 4 - 7 - 1946

Immediate cause of death Premature

birth

accident

Due to birth &amp; miscarriage

going to the airport

Due to birth &amp; miscarriage

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Palmer

M. D. or other

Address Avenue and Date signed 4 May 1946

RECEIVED

APR 15 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

04155  
282

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County.....

City or town.....

St. Mary's

Busal Leonardtown

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

Randall J.

7. Birth date of deceased (mo., day, yr.)

Nov. 23 1924

8. (c) If alive, give age 23 years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8. Birthplace.....

(Town, county, and state) Oklahoma

10. Usual occupation.....

housewife

11. Industry or business

12. Name..... Webster Wilson

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Randall J. Childress

Address.....

Leonardtown, Md.

17. Transportation..... Date thereof 7/24/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Woodward, Oklahoma

18. Funeral director..... G. B. Robinson

Address..... Leonardtown, Md.

19. Date rec'd by registrar 4/24/46

(Date rec'd by registrar) 19

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... St. Mary's

City or town..... Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 23

19 46 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18. to 18.

and that I last saw h. alive on April 23

1946

Immediate cause of death..... Suffocation

Drowning

Due to.....

Drowning

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of April 23 46

Where did injury occur? White Plains, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

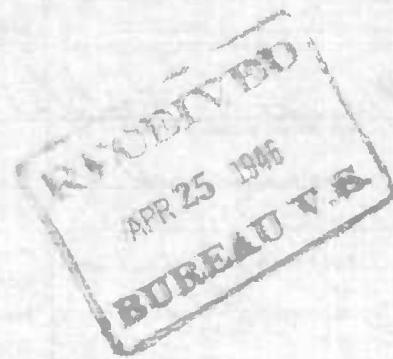
Injured at work? No

23. SIGNATURE..... Francis F. Greenwell, Esq.

M. D. or other

Address.....

Date signed April 23 46



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 158

04056

## CERTIFICATE OF DEATH

Reg. Dist. No. \_\_\_\_\_

## 1. PLACE OF DEATH:

County.....

City or town.....

*St. Marys**Calloway's Chapel*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*all life*

Hospital, institution, or street address where death occurred:

*Hospital*

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Frances Cornelius Cuthember*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**caf.**S*

B.(c) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age ..... years

*Mar 10 - 1944*

8. AGE:

Years

Months

Days

If less than one day

*45**hrs.**min.*

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....*Endisnot*

13. Birthplace.....

14. Maiden name.....*Jene Cuthember*15. Birthplace.....*St. Marys Co Md*16. Informant.....*Jean Cuthember*Address.....*Calloway's Chapel*17. (Burial, cremation, or removal) When?.....*Burial*Date thereof.....*April 25-44*  
(month) (day) (year)Cemetery or crematory.....*St. Georges Cemetery*Location.....*Valley Lee St Marys Land*18. Funeral director.....*Wm. Mallinger Sons*Address.....*Leonardtown Md*

19. 4/24 Date rec'd by registrar

19. 4/24 1946 + C. Cornelius

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md*County.....*St. Marys*City or town.....*Valley Lee*

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*April 25, 1944*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10. to 10. 19. 19. 19.

and that I last saw h. alive on *April 24, 1944*Immediate cause of death.....*Inocardial*

DURATION

Due to.....*Insufficient assimilation of 95 days*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

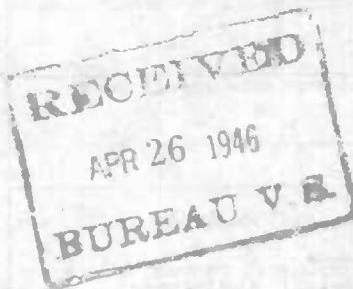
Means of injury.....

Injured at work?

23. SIGNATURE.....*J. J. Greenwell Corcoran*

M. D. or other

Address.....*Leonardtown Md*Date signed *April 24, 1944*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 700

## CERTIFICATE OF DEATH

04057 282

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, institution, or street address where death occurred.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Albert L. Dean

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife.....

Ernest Ernest Dean

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Sept 26 - 1881

8. AGE: Years

Months

Days

If less than one day

64 6 11 hrs. min.

9. Birthplace.....

(Town, county, and state) Maryland

10. Usual occupation.....

Carpenter

## 11. Industry or business

FATHER

12. Name..... Peter Dean

13. Birthplace.....

Maryland Co

MOTHER

14. Maiden name..... Della Dij Dean

15. Birthplace.....

Maryland Co

16. Informant.....

M. M. Deans

Address.....

Hally wood Md

17. Burial, cremation, or removal, Which?

Date thereof..... April 9 - 1945  
(month) (day) (year)

Cemetery or crematory.....

Dij Chapal cemetery

Location.....

Hally wood Md

18. Funeral director.....

W C. Malmyles Sons

Address.....

Leonardtown Md

19. 4/8

19 Date rec'd by registrar

(Data rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County..... Hally wood Md

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 6 1945 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... on April 6th 1945

and that I last saw..... live on.....

Immediate cause of death..... cerebral hemorrhage

&amp; other injuries

DURATION.....

Due to..... Fractured skull &amp; multiple fractures of limb

Due to..... Auto mobile accident limb

Struck by automobile

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Auto mobile Date of April 6 - 1945

Where did injury occur..... Hally bottom 5 March 1945

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... State Highway

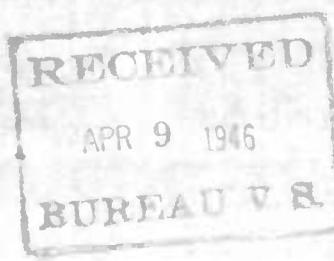
Means of injury..... Struck by automobile

injured at work? walking across

23. SIGNATURE..... J. F. Greenwell, M.D.

M. D. or O. D. or R.N. or

Address..... Leonardtown Md Date signed April 8 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *L.C.*

## CERTIFICATE OF DEATH

64658  
282  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Mechanicsville M.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Wilbur Hallam Dean

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Cassie B.

7. Birth date of

deceased (mo., day, yr.) April 29 1884

8. AGE:

Years      Months      Days      If less than one day

62

11

26

hrs.

min.

9. Birthplace.....

(Town, county, and state) Maryland

10. Usual occupation

Lent Salesman

11. Industry or business

John C. Dean

FATHER

12. Name.....

John C. Dean

13. Birthplace

Maryland

14. Maiden name

Cassie B. Dean

15. Birthplace

Maryland

16. Informant

Cassie B. Dean

Address

Mechanicsville Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

4/29/46

(month) (day) (year)

Cemetery or crematory

Location

Hollywood Md.

18. Funeral director

Address

Leonardtown Md.

19. Date rec'd by registrar

4/28/46

Cause of death

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

219-07-8057

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 26 1946, at 2:45 P.M.  
Feb. 1 - 1946, to April 26 1946  
and that I last saw her alive on April 26 1946

Immediate cause of death

Acute myocarditis

DURATION

3WKS.

Due to

Bronchial Asthma  
Pulmonary Tuberculosis  
~~Urticaria~~  
~~Virus pneumonia~~

3YRS

3YRS -  
2WKS

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

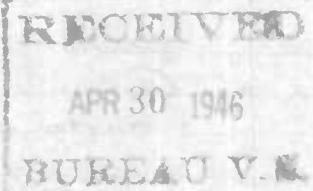
Means of injury

Injured at work?

23. SIGNATURE

Aloysius O. Welch M.D.  
Chapted Md. Date signed 4/28/46

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of **MARYLAND STATE DEPARTMENT OF HEALTH**  
usual residence of deceased is **2411 N. Charles St., Baltimore** *1248*

**FILM No. T 0 1 APR 29 1946**

# CERTIFICATE OF DEATH

Reg. Dist. No. *282*

**1. PLACE OF DEATH:**

County *St. Mary's*

City or town *Clements*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**3. (a) FULL NAME**

*Daniel Maurice Drury*

4. Sex *Male*

5. Color or race *White*

6. (a) Single, married, widowed, or divorced *Married*

8. (b) Name of husband or wife *Betty Lessmann*

7. Birth date of deceased (mo., day, yr.) *July 14, 1876*

6. (c) If alive, give age *70* years

8. AGE: Years *69* Months *9* Days *4* If less than one day  
hrs. *0* min. *0*

9. Birthplace *Hollywood St. Mary's Md.*  
(Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business

12. Name *John W. Drury*

13. Birthplace *St. Mary's Co.*

14. Maiden name *Mary Betty*

15. Birthplace *St. Mary's Co.*

16. Informant *Mrs. Lucy Drury*

Address *Clements MD*

17. Burial *Burial* Date thereof *April 20 1946*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *St. Joseph*

Location *Maryland* *MD*

18. Funeral director *W. B. Watmirey*

Address *Leonardtown MD*

19. *4/10* 1946 Causality

(Date rec'd by registrar)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State *Maryland* County *St. Mary's*

City or town *Clements* (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, same war

**3. (b) Social Security Number**

## MEDICAL CERTIFICATION

20. DATE OF DEATH *April 18 1946* at *7:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Nov 15* to *Apr 18 1946*

and that I last saw him alive on *Apr 18 1946*

Immediate cause of death *Heart Disease*

*Heart Disease*

Due to

Due to

Other conditions *Cardiac Disease*

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

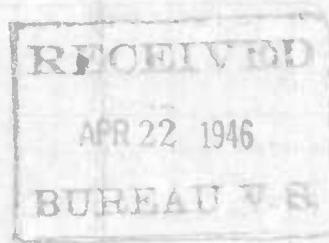
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Paul A. Canale* M. D. or other

Address *1000 E. Pratt St. Baltimore MD* Date signed *4/10/46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 970

64660

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 1881 ?

8. AGE: Years 65? Months Days If less than one day hrs. min.

9. Birthplace..... Washington

(Town, county, and state)

10. Usual occupation..... retired

11. Industry or business.....

FATHER 12. Name..... unknown

13. Birthplace.....

MOTHER 14. Maiden name..... unknown

15. Birthplace.....

16. Informant..... Wm J. Lockridge

Address 410 King St. Alexandria, Va.

17. (Burial, cremation, or removal. Which?) removal Date thereof..... 4/4/46

Cemetery or crematory.....

Location..... Alexandria, Va.

18. Funeral director..... O B. Robinson

Address..... Leonardtown, Md.

19. 4/4 46 Curacao  
(Date rec'd by registrar) 19..... Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County..... H. Mayo -

City or town..... Park Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 3 1946 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1946 to April 1 1946

and that I last saw h.m. alive on March 25 1946

Immediate cause of death.....

Coronary occlusion

Due to..... Generalized arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE

Dr. D. Patrick M. D. or other

Address..... Pearson and Date signed..... 4-3-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18A

## CERTIFICATE OF DEATH

04061  
Reg. Dist. No. 18A

## 1. PLACE OF DEATH:

County.....

St. Mary's

City or town.....

Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 weeks

Hospital, institution, or street address where death occurred:.....

How long in hospital or Institution?.....

## 3. (a) FULL NAME

James C. Greenwell

4. Sex.....

5. Color or race.....

6.(a) Single, married, widowed, or divorced.....

Male

White

Married

Catherine M. Greenwell

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

Dec 29 - 1899

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

46

3

23

hrs.

min.

9. Birthplace.....

(Town, county, and state).....

10. Usual occupation.....

Farmer

11. Industry or business.....

MOTHER FATHER

12. Name.....

C. B. Greenwell

13. Birthplace.....

St. Mary's

14. Maiden name.....

Anna Abell

15. Birthplace.....

St. Mary's

16. Informant.....

C. B. Greenwell Jr

Address.....

Leonardtown, MD

17. Burial.....

Burial

(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)  
April 23 1946

Cemetery or crematory.....

Our Lady Cemetery

Location.....

Medley Neck, MD

18. Funeral director.....

W. G. Mattingly Sons

Address.....

Leonardtown, MD

19. (Data rec'd by registrar).....

4/23/46 Cummins

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town).....

Street No.....

1. F. 10 # /

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 20

19

46 at 10 AM

I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..., to 19...,

and that I last saw h.... alive on on April 20th 1946

Immediate cause of death..... Suffocation

DURATION

Due to Accute Cardiac Insufficiency

+ inability to turn himself

Due to after having fallen face

forward from bed.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

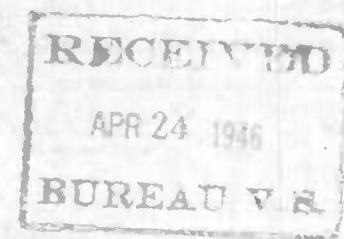
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed 4/28/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 101-6

## CERTIFICATE OF DEATH

14662  
286

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....*St. Mary's*City or town.....*Rural Palermo*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*43 yrs*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Blanche Blanca Herbert*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*m w married*6.(b) Name of husband or wife.....*Blanche Herbert*

7. Birth date of

deceased (mo., day, yr.) *2-14-1877*6.(c) If alive, give age.....*66* years

8. AGE:

Years

Months

Days

If less than one day

*69**1**19*

hrs. .... min.

9. Birthplace.....

*Charleston Md*

(Town, county, and state)

10. Usual occupation.....*og tenn g*

11. Industry or business

12. Name.....*John Herbert*13. Birthplace.....*Charleston*14. Maiden name.....*Ann Rebecca Herbert*15. Birthplace.....*Charleston Md*16. Informant.....*Blanche Herbert*Address.....*Pollards Point Md*17. Burial.....*Burial*

(Burial, cremation, or removal, Which?)

Date thereof.....*4-1-46*  
(month) (day) (year)Cemetery or crematory.....*Sacred Heart*Location.....*Baltimore*18. Funeral director.....*W.C. Mattig & Sons*Address.....*Funeral Home*19. *4-2-1946* R.V. Palmer

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md*County.....*St. Mary's*City or town.....*Rural Palermo*

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*4-2-46* 19..... at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... died on ..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death.....*Cerebral apoplexy, stroke*Due to.....*Cerebral apoplexy*

4 yrs ago

Due to.....*Chronic nephritis*

6 yrs ago

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE.....*Robert V. Palmer* M. D. or otherAddress.....*Funeral Home* Date signed.....*4-3-46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04063  
282

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

St. Marys Hospital  
Leonardtown Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

22 years

Hospital, institution, or street address where death occurred

St. Marys Hospital

How long in hospital or institution?

1 day

## 3. (a) FULL NAME

Gertrude V. Herbert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female color married

B. (b) Name of husband or wife

Edie Herbert

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 27 years

July 25 - 1920

8. AGE: Years

Months

Days

If less than one day

25 8 25 hrs. min.

9. Birthplace

At Marys Md

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

FATHER

12. Name Charles Beander

MOTHER

13. Birthplace St. Marys Co

FATHER

14. Maiden name Mary Evans

MOTHER

15. Birthplace St. Marys Co

16. Informant

Edie Herbert

Address

Leonardtown Md

17.

(Burial, cremation, or removal. Which?)

Date thereof April 26, 1946

(month) (day) (year)

Cemetery or crematory

St. John Cemetery

Location

Hedge Wood Md

18. Funeral director

W.C. Mallin &amp; Son

Address

Leonardtown Md

19.

4/19 1946

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Leonardtown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1946 at 12:45 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 18 1946 to April 18 1946

and that I last saw h.e.r. alive on April 18 1946

Immediate cause of death

Coma

Due to Diabetes Mellitus

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Fuhs, M.D. or other

Address Leonardtown, Md Date signed 4/19/46

RECEIVED

APR 22 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04664

## CERTIFICATE OF DEATH

Reg. Dist. No. 264

## 1. PLACE OF DEATH:

Mechanicsville Md

County

City or town

St. Mary's Co

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

## 3. (a) FULL NAME

WEBSTER LEO Higgs

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

B. (b) Name of husband or wife

wife Anna P. Higgs

7. Birth date of deceased (mo., day, yr.) 5-17-1877

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
68 11 29 hrs. min.9. Birthplace MECHANICSVILLE MD  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Henry E. Higgs

13. Birthplace St. Mary's Co. Md

14. Maiden name Mary D. Hayden

15. Birthplace St. Mary's Co. Md

16. Informant Anna P. Higgs

Address Mechanicsville Md.

17. Burial Date thereof April 10/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ Church

Location Chaptico Rd

18. Funeral director Harriet &amp; Ryan

Address Meadow Rd.

19. Date rec'd by registrar April 9 1946 McIlwain

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. Mary

City or town Mechanicsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1946 to April 7 1946  
and that I last saw him alive on April 7 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

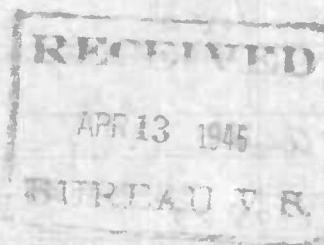
Alceius C. Welch M.D.

M. D. or other

Address Chaptico Maryland Date signed 4/8/46

UNITED STATES GOVERNMENT  
GENERAL INSPECTORATE  
STANISLAVSKY

1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 146

## CERTIFICATE OF DEATH

04065  
Reg. Dist. No. 287

## 1. PLACE OF DEATH:

County..... *St. Marys*  
 City or town..... *Leonardtown* Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *10 days*Hospital, institution, or street address where death occurred:  
*St. Mary's Hospital*How long in hospital or institution? *12 days*

## 3. (a) FULL NAME

*Samuel B. Hill*4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Widowed*6.(b) Name of husband or wife..... *Edgar Hill*7. Birth date of deceased (mo., day, yr.) *May 11-1883*

6.(c) If alive, give age ..... years

8. AGE: Years *62* Months *11* Days *3* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace..... *Mechanicsville St. Marys Md*  
(Town, county, and state)10. Usual occupation..... *merchant*

## 11. Industry or business

12. Name..... *Frank Hill*13. Birthplace..... *St. Marys Co*14. Maiden name..... *Mary Elizabeth Hill*15. Birthplace..... *St. Marys Co*16. Informant..... *Cullins Hill*Address..... *Abells*17. Burial..... *Burial* Date thereof..... *April 16-1946*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... *Scared Heart Cemetery*Location..... *Brush Wood* Md18. Funeral director..... *W. C. Matson & Sons*Address..... *Lionshead Ln. Leonardtown MD*19. Date rec'd by registrar..... *4/15/46* M. D. or other..... *Caucases*  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *St. Marys*City or town..... *Brush Wood*  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, came war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *April 14 1946* at *9:15 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Mar 6 1946* to *Apr 14 1946*  
 and that I last saw him alive on *Apr 13 1946*

Immediate cause of death.....

*Curbosis of Liver* ?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

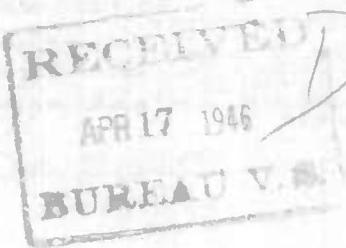
Means of injury.....

Injured at work?

23. SIGNATURE..... *Paul A. Caucases*

M. D. or other.....

Address..... *Leonardtown* Date signed..... *4/15/46*



Dr. Pater, M.D.

Evidence for the change of MARYLAND STATE DEPARTMENT OF HEALTH  
age of deceased is shown on 2411 N. Charles St., Baltimore

(4066)

FILM No. I 04 JUN - 4 1946

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

County

City or town

*St. Marys  
Leonardtown*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

*2 days*

Hospital, institution, or street address where death occurred:

*St. Marys Hospital*

How long in hospital or institution?

*2 days*

3. (a) FULL NAME

*Margaret Helen Knott*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female married*

*Charles Henry Knott*

9. (b) Name of husband or wife

5. (c) If alive, give age

years

7. Birth date of  
deceased (mo. day, yr.)

*July 24 1917*

8. AGE:

Years

Months

Days

If less than one day

*28 7 9 28*

hrs.

min.

9. Birthplace

*Leathland St. Marys MD*

(Town, county, and state)

10. Usual occupation

*House Wife*

11. Industry or business

12. Name

*George Green*

13. Birthplace

*St. Marys Co*

14. Maiden name

*Emma Greenwell*

15. Birthplace

*St. Marys Co*

16. Informant

*Charles H. Knott*

Address

*St. Marys City MD*

17. Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

*St. Marys City*

Location

*St. Marys City MD*

19. Funeral director

*W.C. Stratton & Son*

Address

*Seneca Valley End*

19. 4/23 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

*Maryland County*

City or town

*St. Marys City*

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

*April 21*

19. *1946 at 11:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*April 19* 1946 to *April 21* 1946

and that I saw her alive on *April 21* 1946

Immediate cause of death

*Pneumonia (Obit)*

DURATION

*4 day*

Due to

Due to

Other conditions

*Diabetic acidosis*

*3 days*

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

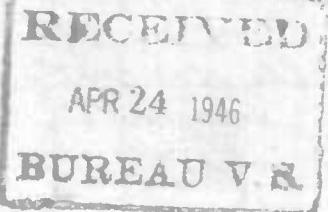
23. SIGNATURE

*Julian S. Lane*

M. D. or other

Date signed *4/23/46*

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 943

04067

## CERTIFICATE OF DEATH

Reg. Dist. No. 280

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

madeline F. matthews

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (c) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

John W. Matthews

13. Birthplace

Washington DC

MOTHER

14. Maiden name

Keaney R. Matthews

15. Birthplace

Washington DC

16. Informant

John W. Matthews

Address

1121 Columbia Rd NW

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Harmony Cemetery

Location

Washington DC

18. Funeral director

Robert T. Palmer

Address

1828 17th St NW

19. 4-22

19-46

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4 - 21 -

1946 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her dead 4-21-1946

Immediate cause of death

acute indigestion from eating

Due to chief Recurrence

Due to Angina Pectoris

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of .....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

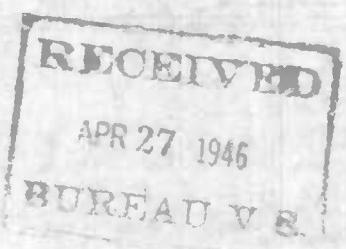
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 4-22-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

040681  
Reg. Dist. No. 1

## 1. PLACE OF DEATH:

St. Mary's County

City or town US NAS Patuxent River, Md.

(If outside city or town limits, write RURAL and give nearest town)

1 1/2 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Dispensary, US NAS Patuxent River, Md.

How long in hospital or institution?

1 1/2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's

City or town Rural Great Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No. Chancellors Run Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## 3. (a) FULL NAME

NORRIS, Raymond

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
-------------	------------------------	--

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 16 December 1887 1927

(c) If alive, give age years

8. AGE: Years Months Days It less than one day  
18 3 23 hrs. min.9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Student

11. Industry or business High school

12. Name Joseph Norris

13. Birthplace Hollywood, Md

14. Maiden name Lula Abel

15. Birthplace California, Md

16. Informant Joseph B. Norris

Address Great Mills, Md

17. Burial Date thereof April 11, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Face Cemetery

Location Great Mills, Md

18. Funeral director Mattingly Funeral Home

Address Leonardtown, Maryland

19. April 9, 1946  
(Date rec'd by registrar)By Reg. No.  
Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946 at 3:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1946 to April 8 1946

and that I last saw him alive on April 8 1946

Immediate cause of death Intracranial Injury

Due to Fractured skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of April 7th

Where did injury occur? California St. Mary's Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway 235

Means of injury Auto accident Injured at work? No

W. H. GULLEDGE, Commander (MC) USN

23. SIGNATURE

US NAS Patuxent River Md. M.D. or other

Address Date signed 4-8-46

